United States Department of Labor
Employees' Compensation Appeals Board

R.A., Appellant	)	
	)	**Docket No. 18-1331**
and	)	**Issued: April 24, 2019**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Chantilly, VA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 16, 2018 appellant filed a timely appeal from a November 30, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence on appeal. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 14 percent permanent impairment of his right upper extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On February 4, 2011 appellant, then a 53-year-old rural carrier, filed a traumatic injury claim (Form CA-1) alleging that, on January 26, 2011, he slipped on ice and fell backwards, injuring both elbows and his low back while in the performance of duty. He stopped work on January 27, 2011. On April 5, 2011 OWCP accepted the claim for sprains of the right elbow, forearm, and ulnar collateral ligament, and a lumbar sprain. It assigned the claim File No. xxxxxx791. OWCP later expanded acceptance of the claim to include synovitis and tenosynovitis of the right elbow. It paid appellant wage-loss compensation for temporary total disability commencing March 25, 2011.[3]

In a report dated March 21, 2011, Dr. Robert P. Nirschl, an attending Board-certified orthopedic surgeon, diagnosed a healing injury of the right medial ulnar collateral ligament. He held appellant off from work. In follow-up reports through June 10, 2011, Dr. Nirschl diagnosed calcific medial tendinosis of the right elbow, intermittent right cubital tunnel syndrome with ulnar nerve entrapment, mild calcific lateral elbow tendinosis, and iatrogenic edema of the right wrist and hand.

On July 26, 2011 Dr. Nirschl performed surgical resection and repair of right medial elbow tendinosis, partial right medial epicondylectomy with excision of a major osteophytic spur, and decompression of the right ulnar nerve. In a duty status report (Form CA-17) dated September 23, 2011, he indicated that he did not release appellant to return to work. Dr. Nirschl provided periodic progress notes.[4] He returned appellant to full-duty work, effective February 17, 2012. Appellant returned to full-time work on February 17, 2012.

In a report dated November 14, 2013, Dr. Sarah Pettrone, an attending Board-certified orthopedic surgeon and hand surgeon, noted appellant's symptoms of swelling and discoloration of the right elbow with stiffness in the right small finger. On examination, she observed full range of right elbow motion, diminished pinch strength in the right hand, and a negative Tinel's sign at the right cubital tunnel. Dr. Pettrone opined that additional surgery would not be of benefit, as appellant's postoperative electromyography (EMG) studies had been normal.

On August 9, 2014 appellant filed a second traumatic injury claim (Form CA-1) alleging that, when loading mail trays into his delivery vehicle earlier that day, he injured his neck, back, left side, and right shoulder while in the performance of duty. OWCP assigned the claim File No. xxxxxx432. Appellant stopped work on August 9, 2014. On October 3, 2014 OWCP accepted

[3] Appellant participated in physical therapy treatments in March and April 2011.

[4] Appellant underwent physical therapy treatments, periodic cortisone injections, and acupuncture treatments to the right elbow from September 2011 through December 2012.

the claim for a right rotator cuff tear. It paid appellant wage-loss compensation for total disability commencing October 4, 2014.

On December 12, 2014 Dr. Derek Ochiai, an attending Board-certified orthopedic surgeon, performed an authorized right shoulder arthroscopy with a one-anchor SLAP (superior labral tear from anterior to posterior) repair, subacromial bursectomy, two-anchor rotator cuff repair, and right biceps tenodesis.

On June 1, 2015 appellant claimed a schedule award (Form CA-7) under OWCP File No. xxxxxx791.

In a report dated June 30, 2015, Dr. Taeho Kim, an attending Board-certified internist, requested an impairment rating of appellant's right upper extremity. He noted that appellant had sustained a right rotator cuff tear and left biceps rupture at work on August 9, 2014 and had not returned to work following that injury.

OWCP, by development letter dated June 18, 2015, notified appellant of the type of additional evidence needed to establish his schedule award claim, including a statement from his attending physician that the accepted condition had reached maximum medical improvement (MMI), and an impairment rating utilizing the appropriate portions of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*).[5] It afforded appellant 30 days for submission of the necessary evidence. No additional evidence was received.

By decision dated July 21, 2015, under File No. xxxxxx791, OWCP denied appellant's schedule award claim, finding that the medical evidence of record was insufficient to establish that he had reached MMI or sustained permanent impairment of a scheduled member or function of the body.

On August 7, 2015 appellant requested a review of the written record by an OWCP hearing representative. He submitted a February 6, 2012 report from Dr. Nirschl, finding that appellant had attained MMI and could resume full-duty work as of February 17, 2012. Referring to Table 15-4 of the A.M.A., *Guides*,[6] Dr. Nirschl opined that appellant had a class 1E impairment of the right upper extremity for epicondylitis surgery of flexor origin, equaling seven percent impairment of the right upper extremity.[7] Appellant also provided an October 14, 2014 report from Dr. Kim diagnosing a full-thickness tear of the right supraspinatus tendon under OWCP File No. xxxxxx432.

On February 19, 2016 OWCP obtained a second opinion report from Dr. Chester DiLallo, a Board-certified orthopedic surgeon regarding appellant's work limitations. Dr. DiLallo opined

[5] A.M.A., *Guides* (6th ed. 2009).

[6] Table 15-4, pages 398 to 400 of the sixth edition of the A.M.A., *Guides* is titled "Elbow Regional Grid: Upper Extremity Impairments."

[7] Appellant also submitted acupuncture treatment notes from Dr. Kim dated from January 26, 2012 to October 24, 2017.

that appellant could perform full-time modified work with restrictions relative to pulling, pushing, and lifting limited to 20 pounds. On September 17, 2016 appellant returned to full-time limited-duty work as a webcam observer.

On March 13, 2017 appellant claimed a schedule award (Form CA-7) under OWCP File No. xxxxxx432. In support of his claim, he submitted a functional capacity evaluation (FCE) and impairment rating dated February 9, 2017 by Sean Gorman, a physical therapist. Mr. Gorman related appellant's symptoms of right shoulder pain with daily activities, but that he could perform self-care activities unassisted. Appellant completed a *Quick*DASH questionnaire with a score of 75. On examination, he noted ranges of motion for the right shoulder of 135 degrees flexion, 30 degrees extension, 100 degrees abduction, 30 degrees adduction, 35 degrees internal rotation, and 50 degrees external rotation. Mr. Gorman found right elbow range of motion within normal limits in all planes. He also noted 4/5 weakness in right shoulder flexion, extension, abduction, adduction, right elbow flexion, extension, and pronation deficits in all planes of right shoulder and elbow motion. Mr. Gorman observed 3/5 weakness in right shoulder internal and external rotation and right elbow supination.

Referring to Table 15-5 of the A.M.A., *Guides*, the Shoulder Regional Grid, Mr. Gorman selected a class 1 diagnosis-based impairment (CDX) for a rotator cuff tear. He explained that a range of motion (ROM) rating methodology would prove the most accurate characterization of appellant's impairment based on his clinical presentation. Mr. Gorman assessed 14 percent impairment of the right upper extremity for loss of motion according to Table 15-34.[8] He found a range of motion grade modifier of 2 for a 12 to 23 percent range of motion impairment according to Table 15-35.[9] Mr. Gorman also found a grade modifier for functional history (GMFH) of 2 due to pain with normal activities, but unassisted self-care, and a *Quick*DASH score of 75 percent. He did not assess a grade modifier for clinical studies (GMCS) or grade modifier for findings on physical examination (GMPE). Applying the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or (2-1) + (0-1) + (0-1), resulted in a net modifier of zero. Mr. Gorman therefore assessed 14 percent permanent impairment of the right upper extremity.

By decision dated June 16, 2017, under File No. xxxxxx432, OWCP denied appellant's schedule award claim as he did not submit medical evidence demonstrating a permanent impairment of a scheduled member of the body. It found Mr. Gorman's opinion was of no probative medical value as physical therapists are not considered physicians under FECA.

On July 14, 2017 appellant requested reconsideration under OWCP File No. xxxxxx432. He submitted a copy of Mr. Gorman's February 9, 2017 report countersigned by Dr. Kim on June 20, 2017. Dr. Kim confirmed that he had reviewed Mr. Gorman's findings and concurred with his opinion.

By letter dated October 4, 2017, OWCP requested that an OWCP district medical adviser (DMA) review the medical record and provide an impairment rating for the right upper extremity.

[8] Table 15-34, page 475 of the sixth edition of the A.M.A., *Guides* is titled "Shoulder Range of Motion."

[9] Table 15-35, page 477 of the sixth edition of the A.M.A., *Guides* is titled "Range of Motion Grade Modifiers."

It provided a statement of accepted facts (SOAF), which included the right elbow injuries accepted under OWCP File No. xxxxxx791 and the July 26, 2011 surgery.

In a report dated October 6, 2017, Dr. Michael M. Katz, a Board-certified orthopedic surgeon acting as a DMA, reviewed the medical record and SOAF. He found that appellant had attained MMI as of February 7, 2017, the date of Mr. Gorman's evaluation. Dr. Katz noted that according to the diagnosis-based impairment (DBI) rating methodology under Table 15-5,[10] appellant had sustained a class 1 full-thickness rotator cuff tear with normal motion, with a default value of five percent. Applying the next adjustment formula, (GMFH-CDX) + (GMPE-CDX), or (2-1) + (2-1), resulted in a net modifier of plus 2, which raised the default five percent value upward to seven percent permanent impairment of the right upper extremity. Dr. Katz noted that according to the A.M.A., *Guides* and FECA Bulletin No. 17-06, if more than one method was appropriate for rating the impairment, the method which produced the higher impairment rating should be adopted. As the ROM method resulted in 14 percent impairment rating and the DBI method resulted in 7 percent impairment rating, Dr. Katz found that the ROM rating method should be applied to appellant's case.

By decision dated October 12, 2017, under File No. xxxxxx432, OWCP vacated its June 16, 2017 decision and granted appellant a schedule award for 14 percent permanent impairment of the right upper extremity. The period of the award ran from February 7 to December 9, 2017.

In a memorandum dated October 20, 2017, OWCP combined File Nos. xxxxxx432 and xxxxxx791, designating File No. xxxxxx432 as the master file number.

By decision dated November 30, 2017, under File No. xxxxxx791, an OWCP hearing representative affirmed OWCP's July 21, 2015 decision which denied appellant's schedule award claim for permanent impairment based on the accepted right elbow conditions. He found that as appellant's right shoulder had been rated using the ROM method, only the single most impairing diagnosis in the region could provide the basis for the ROM rating. The hearing representative concluded, therefore, that OWCP properly granted appellant a schedule award for permanent impairment of the right shoulder and not the right elbow as the shoulder impairment was the greater of the two.

LEGAL PRECEDENT

The schedule award provisions of FECA,[11] and its implementing federal regulations,[12] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For

[10] Table 15-5, pages 401 to 405 of the sixth edition of the A.M.A., *Guides* is titled "Shoulder Regional Grid: Upper Extremity Impairments."

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[13] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[14]

In addressing upper extremity impairments, the sixth edition requires identifying the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).[15] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

The A.M.A., *Guides* also provide that ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI sections are applicable.[16] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[17] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[18]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating upper extremity impairments.[19] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an*

[13] *Id.* at § 10.404(a).

[14] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[15] A.M.A., *Guides* 494-531.

[16] *Id*. at 461.

[17] *Id.* at 473.

[18] *Id.* at 474.

[19] FECA Bulletin No. 17-06 (May 8, 2017).

impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)[20]

ANALYSIS

The Board finds that the case is not in posture for decision.

In a report dated February 9, 2017 from Mr. Gorman, a physical therapist and countersigned on June 20, 2017 by Dr. Kim it found that appellant's right shoulder impairment should be calculated using the ROM methodology as Table 15-5 of the A.M.A., *Guides*, the shoulder regional grid, as it provided a more accurate description of appellant's impairment than the DBI method.[21] As he did not have normal motion, Dr. Kim properly rated appellant's right shoulder impairment using the ROM methodology set forth at Table 15-34 on page 475. Dr. Kim concluded that appellant had 14 percent right upper extremity impairment due to loss of motion of the right shoulder. An OWCP DMA reviewed Dr. Kim's opinion and concurred with his use of the ROM to rate the impairment of the right shoulder.

As noted, FECA Bulletin No. 17-06 indicates that in measuring range of motion, the evaluator should obtain three independent measurements and the greatest measurement used to determine the extent of impairment.[22] The record does not establish that Mr. Gorman, the physical therapist who performed the impairment rating later adopted by Dr. Kim, obtained three measurements prior to rating the extent of appellant's permanent impairment. FECA Bulletin No. 17-06 provides that the claims examiner should instruct the physician to obtain three independent measurements.

On remand OWCP should obtain a supplemental report from Dr. Kim containing three independent range of measurements for the right shoulder pursuant to FECA Bulletin No. 17-06. After such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's entitlement to a schedule award for a permanent impairment of the right upper extremity.[23]

CONCLUSION

The Board finds that the case is not in posture for decision.

[20] *Id.*

[21] *See G.S.*, Docket No. 14-1732 (issued December 15, 2014) (a physical therapy report constitutes medical evidence when countersigned by a physician).

[22] *Id.*

[23] *See J.V.*, Docket No. 18-1052 (issued November 8, 2018); *J.F.*, Docket No. 17-1726 (issued March 12, 2018).

ORDER

IT IS HEREBY ORDERED THAT the November 30, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: April 24, 2019
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board